IDAHO DEPARTMENT OF
HEALTH & WELFARE

JAMES E. RISCH – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

CERTIFIED MAIL: 7000 0500 0001 5168 3467

August 23, 2006

Rochelle Frank, Administrator
Mountain View Care Center
500 Polk Street East
Kimberly, ID 83341

Provider #: 135084

Dear Ms. Frank:

On **August 15, 2006**, a Complaint Investigation survey was conducted at Mountain View Care Center by the Bureau of Facility Standards/Department of Health & Welfare to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. **This survey found the most serious deficiencies to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy, as evidenced by the attached CMS-2567 whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies/Plan of Correction, CMS Form 2567L, listing Medicare/Medicaid deficiencies, and a similar form listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **Please provide ONLY ONE completion date for each Federal/State Tag in column X5 (Complete Date), to signify when you allege that each tag will be back in compliance. NOTE: The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Date Certain" (listed on page 2). After each deficiency has been answered and dated, the administrator should sign both the CMS Form 2567L and State Statement of Deficiencies, in the spaces provided, and return the originals to this office.**

Your Plan of Correction (PoC) for the deficiencies must be submitted by **September 5, 2006**. Failure to submit an acceptable PoC by **September 5, 2006**, may result in the imposition of civil monetary penalties by **September 25, 2006**.

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
- Include dates when corrective action will be completed.

All references to federal regulatory requirements contained in this letter are found in *Title 42, Code of Federal Regulations*.

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS), if your facility has failed to achieve substantial compliance by **September 19, 2006 (Date Certain)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **September 19, 2006**. A change in the seriousness of the deficiencies on **September 19, 2006**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **September 19, 2006** includes the following:

Denial of payment for new admissions effective **November 15, 2006**. [42 CFR §488.417(a)]

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **February 15, 2007**, if substantial compliance is not achieved by that time.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact Loretta Todd, R.N. or Lorene Kayser, L.S.W., Q.M.R.P., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0036, Phone #: (208) 334-6626, Fax #: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **August 15, 2006** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

http://www.healthandwelfare.idaho.gov/_Rainbow/Documents/medical/2001_10.pdf
http://www.healthandwelfare.idaho.gov/_Rainbow/Documents/medical/2001_10_attach1.pdf

This request must be received by **September 5, 2006**. If your request for informal dispute resolution is received after **September 5, 2006**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact us at (208) 334-6626.

Sincerely,

Lorene Kayser

LORENE KAYSER, L.S.W., Q.M.R.P.
Supervisor
Long Term Care

LKK/dmj

Enclosures

IDAHO DEPARTMENT OF
HEALTH & WELFARE

JAMES E. RISCH – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
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FAX 208-364-1888

September 8, 2006

Rochelle Frank, Administrator
Mountain View Care Center
500 Polk Street East
Kimberly, ID 83341

Provider #: 135084

Dear Ms. Frank:

On **August 15, 2006,** a Complaint Investigation was conducted at Mountain View Care Center. Marcia Key, R.N., Winifred Young, R.N. and Kari Head, R.D. conducted the complaint investigation. A total of 16 survey hours were required to complete this investigation. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00001612

ALLEGATION #1:

The complainant stated the air conditioners are not working and the building temperature was 97 degrees. The facility has failed to repair the air conditioners or to run fans until they were repaired. An identified resident had complained that her room was too hot.

FINDINGS:

The complaint team entered the facility at on July 14, 2006, at 1:45 p.m. An immediate tour of the facility was conducted with the maintenance supervisor. Temperatures were checked with two thermometers in random residents' rooms, including the identified resident's room, the day room and dining rooms. All temperatures were below the maximum allowable temperature of 80 degrees Fahrenheit.

The identified resident and seven random residents were interviewed. Each resident stated the facility's temperature was comfortable. They did not recall any day or days when the facility was

too hot. The identified resident had a large fan on in her room. Several residents were observed in bed with light quilts or covers on top of them. Random residents' rooms were observed to have fresh ice water in the rooms. There was also a water dispenser in the day/dining room.

The maintenance supervisor was interviewed. He indicated that on July 7, 2006, the swamp cooler malfunctioned, but it worked sufficiently to maintain the north hall section of the facility at a comfortable temperature. There were no other problems with the remaining units. By July 12, 2006, all the units had been serviced.

The complaint team entered the facility again on August 14 and 15, 2006. The facility's temperature was quite comfortable in all residents' areas.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The complainant stated the facility was not maintaining an adequate amount of food supplies to prepare the menu selections. On July 2, 2006, residents were asking for sandwiches but there was no bread in the facility.

FINDINGS:

The kitchen tour was conducted immediately upon entering the facility on August 14, 2006. There was sufficient amount of food storage in the facility as required, to include bread, milk eggs, meat and peanut butter. Random residents were interviewed. There were no identified concerns about the meals and snacks served. The resident council and grievances were reviewed for a three month time period. There were no identified concerns regarding availability of food.

Random kitchen staff were interviewed and indicated if they do not have a particular needed food item, they can purchase it at a local grocery store.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The complainant stated that menus were not being posted or followed and substitutions were not being approved by the dietitian.

FINDINGS:

The menus were observed to be posted for residents to see. Several residents showed the

surveyor where the posting was located.

The spread sheets for the current week were reviewed. These were approved by the dietitian.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

The complainant stated that several of the kitchen cabinets were moldy and smelled of mold. According to the complainant, the equipment room also smelled of mold.

FINDINGS:

The equipment room was not observed to smell of mold; however, the facility was cited at F371 for failure to maintain a sanitary kitchen environment free of mold.

CONCLUSIONS:
Substantiated. Federal and State deficiencies related to the allegation are cited.

ALLEGATION #5:

The complainant stated the facility was having financial difficulty to the degree that the telephones were disconnected on July 7, 2006. Food vendors were refusing to deliver food supplies unless the facility pays cash upon delivery. An unidentified nurse reported that the pharmacy was not filling residents' medications due to a large outstanding bill.

FINDINGS:

The regional manager and random staff were interviewed. The telephone is connected to the local cable system, so when that is not functioning, the telephones do not work. They have an adequate backup plan when this occurs. There has been no instance when the telephone was disconnected due to nonpayment.

There have been no food shortages due to nonpayment. Cash on delivery is acceptable.

Four nurses were interviewed during the investigation. Each person stated there have been no concerns regarding a pharmacy not delivering medication due to nonpayment. There have been circumstances when a medication was unavailable. In that case the staff contacts a second pharmacy for delivery.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #6:

The complainant stated that residents were being rushed through the supper meal or are not being assisted with the meal as needed so the staff could have the residents in bed by 6 p.m.

FINDINGS:

During the investigation a supper meal was observed. The staff was assisting the residents as needed and no residents were rushed to eat.

Random residents were interviewed. Each resident stated they were able to go to bed each evening at the time they wanted. They were not required to go to bed at the convenience of the staff.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

Based on the findings of the complaint investigation, deficiencies were cited and included on the survey report. No response is necessary to this complaint report, as it will be addressed in the Plan of Correction.

If you have questions or concerns regarding our investigation, please contact us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

Marcia Key

MARCIA KEY, R.N.
Health Facility Surveyor
Long Term Care

MK/dmj

IDAHO DEPARTMENT OF
HEALTH & WELFARE

JAMES E. RISCH – Governor
RICHARD M. ARMSTRONG – Director

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September 8, 2006

Rochelle Frank, Administrator
Mountain View Care Center
500 Polk Street East
Kimberly, ID 83341

Provider #: 135084

Dear Ms. Frank:

On **August 15, 2006**, a Complaint Investigation was conducted at Mountain View Care Center. Marcia Key, R.N., Winifred Young, R.N. and Kari Head, R.D. conducted the complaint investigation. A total of 16 survey hours were required to complete this investigation. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00001650

ALLEGATION #1:

The complainant stated the facility is hot. An identified resident could verify this.

FINDINGS:

The complaint team entered the facility at on July 14, 2006, at 1:45 p.m. An immediate tour of the facility was conducted with the maintenance supervisor. Temperatures were checked with two thermometers in random residents' rooms, including the identified resident's room, the day room and dining rooms. All temperatures were below the maximum allowable temperature of 80 degrees Fahrenheit.

The identified resident and seven random residents were interviewed. Each resident stated the facility's temperature was comfortable. They did no recall any day or days when the facility was too hot. The identified resident had a large fan on in her room. Several residents were observed in bed with light quilts or covers on top of them. Random residents' rooms were observed to have fresh ice water in the rooms. There was also a water dispenser in the day/dining room.

The maintenance supervisor was interviewed. He indicated that on July 7, 2006, the swamp cooler malfunctioned, but it worked sufficiently to maintain the north hall section of the facility at a comfortable temperature. There were no other problems with the remaining units. By July 12, 2006, all the units had been serviced.

The complaint team entered the facility again on August 14 and 15, 2006. The facility's temperature was quite comfortable in all residents' areas.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The complainant stated the following concerns about the kitchen:

They ran out of bread. Aides came to kitchen to get a tomato sandwich for a resident but there was no bread, so she got nothing to eat. This occurred within the last month.

One identified company will not deliver bread unless it receives cash payment at time of delivery.

On July 2, 2006, a staff member had to go to store to get 10 gallons of milk as the facility only had skim milk in the kitchen.

They ran out of peanut butter. Several identified residents wanted peanut butter and jelly sandwiches instead of the menu meal.

In the recent past, they ran out of eggs from an identified distributor. A second delivery person gave the facility eggs but the complainant was not sure if the eggs were pasteurized.

FINDINGS:

The kitchen tour was conducted immediately upon entering the facility on August 14, 2006. There was sufficient amount of food storage in the facility as required, to include bread, milk, eggs, meat and peanut butter. Random residents were interviewed. There were no identified concerns about the meals and snacks served. The resident council and grievances were reviewed for a three month time period. There were no identified concerns regarding availability of food.

It is an expectation that if a facility runs out of a particular food item, that item is obtained at a local food store. There is no regulation against a facility paying cash on delivery for food supplies.

The eggs were observed to be pasteurized.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The complainant stated the cupboards on the south side of the kitchen, on the floor level, smell strongly of mold, which is coming from the basement.

The staff is stacking wet dishes, especially the covers for the plates. Silverware is spotted. The clean water pitchers are being stored in the employee break room until staff can get them for residents use.

An identified staff member is not taking food temperatures prior to serving the food.

The staff is not recording refrigerator temperatures.

FINDINGS:

The facility was cited at federal regulation F371, and state regulation C325 for failure to ensure sanitary conditions were maintained in the following areas; service of foods at appropriate temperatures, appropriate storage of clean and sanitized equipment and utensils, maintaining dishwashing equipment to prevent deposits of residue, and proper monitoring of cold food storage temperatures.

The facility was also cited at state regulation C299 for not ensuring alternative menus were prepared a week in advance, or that a record was kept of the alternate menus that were served.

CONCLUSIONS:
Substantiated. Federal and State deficiencies related to the allegation are cited.

ALLEGATION #4:

The complainant identified the following concerns:

Opened items in the refrigerator are not identified or dated.

Staff pour milk two meals ahead of time, this includes over night for the morning meal.

One cook is cooking the food too early and leaving it sit on the stove. One staff purees the bread and eggs one day ahead of time.

The staff does not always add butter and jam to the pureed toast mix.

FINDINGS:

During the tour of the kitchen the refrigerator was observed. All open items were identified and dated.

The milk and other drinks were not poured prior to the acceptable time frame.

The identified cook was observed during food preparations. She did not cook the food beyond the maximum allowed time frame and did not leave food on the stove for an unacceptable time period.

The second identified staff member was not on duty at the time of the investigation. No food items were observed to have been prepared the day prior to the investigation.

The surveyors asked for a test tray and tasted the pureed bread item for the day. Both surveyors tasted the food item and determined it had a good flavor.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #5:

The complainant stated that one time approximately two weeks ago a family member of an identified resident came to the kitchen asking for ice water for the resident. The complainant acknowledged the family member had not complained that this had occurred more than once.

FINDINGS:

A tour of the facility was conducted on July 14, August 14 and 15, 2006. All residents' rooms were observed for availability of fresh water. Most residents had fresh water pitchers in their rooms, including the identified resident. The staff identified which residents required thickened liquids. At random times during the three day investigation the identified resident was observed to have fresh water near her bedside.

Random residents were interviewed. Each resident stated they routinely get fresh water delivered to their rooms twice daily. Random staff were also interviewed and stated the water cart is passed each morning and afternoon routinely.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #6:

The complainant stated snacks and juices are not being offered on the evening shift. The complainant has not witnessed this but is aware that many snacks are returned to the kitchen for the next snack time. There are three identified residents who could be interviewed.

A meal tray for a fourth identified resident came back to the kitchen untouched. The complainant indicated she did not know the circumstances. The resident is unable to feed herself.

FINDINGS:

Two of the identified residents were unable to be interviewed. The third resident was observed to eat a midmorning and afternoon snack. Random residents were interviewed. They stated they always received or were offered snacks and juices between meals and in the evening. Random staff was interviewed. They stated that if a resident was asleep they might wake them or ask them later if they wanted a snack.

The fourth identified resident's chart was reviewed and she was observed during a supper and breakfast meal. The staff was attentive to her and fed her without rushing her through the meals. The meal monitor records documented the resident refused several meals each month.

Staff indicated they offer the resident snacks and juices between meals.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

Based on the findings of the complaint investigation, deficiencies were cited and included on the survey report. No response is necessary to this complaint report, as it will be addressed in the Plan of Correction.

If you have questions or concerns regarding our investigation, please contact us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

Marcia Key

MARCIA KEY, R.N.
Health Facility Surveyor
Long Term Care

MK/dmj

IDAHO DEPARTMENT OF
HEALTH & WELFARE

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September 8, 2006

Rochelle Frank, Administrator
Mountain View Care Center
500 Polk Street East
Kimberly, ID 83341

Provider #: 135084

Dear Ms. Frank:

On **August 15, 2006**, a Complaint Investigation was conducted at Mountain View Care Center. Marcia Key, R.N., Winifred Young, R.N. and Kari Head, R.D. conducted the complaint investigation. A total of 16 survey hours were required to complete this investigation. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00001696

ALLEGATION #1:

The complainant said an identified resident could not eat or drink independently. Very often there was no water in her room. She appeared thirsty because she would drink two glasses for the complainant. Staff did not give her enough fluids to drink.

FINDINGS:

A tour of the facility was conducted at the start of the investigation. All residents' rooms were observed for availability of fresh water. Most residents had fresh water pitchers in their rooms, including the identified resident. The staff identified which residents required thickened liquids. At random times during the two day investigation the identified resident was observed to have fresh water near her bedside. During observation of her cares a staff member was observed to assist her to drink water. The resident did not have physical signs of dehydration. The resident was also observed during a breakfast and supper meal. The staff was observed to offer the resident the fluids on her tray. Review of her meal monitor records for May through July

documented the resident drank a sufficient amount of fluids when she would agree to eat and drink. There were thirteen documented refusals of fluids during meals in May, eight fluid refusals during June, and nine fluid refusals in July, 2006.

Random residents were interviewed. Each resident stated they routinely get fresh water delivered to their rooms twice daily.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The complainant stated the identified resident had frequent bladder infections.

FINDINGS:

The identified resident's record was reviewed. The resident was placed on antibiotics for positive urine cultures in January, May, and July 2006. There was no documented evidence that the resident experienced signs and symptoms of urinary tract infections associated with the positive urine cultures.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The complainant stated that when a visitor saw an identified resident in the evening, her meal tray had not been touched. The resident does eat when the visitor feeds her. The aides are good and caring but they do not have the time to feed the resident as she eats very slowly. The resident has lost weight. She weighed about 150 pounds but is down to about 135 pounds.

FINDINGS:

During the investigation the resident was observed during a breakfast and supper meal. The staff was attentive to her and fed her without rushing her through the meals. The meal monitor records documented the resident refused several meals each month. The nutrition documentation identified the resident's usual body weight was 150 - 160 pounds, however, her ideal body weight was 115 pounds +/- 10%. The "nutrition at risk" team monitored her weight and intake closely. Her weight in March 2006, was 137 pounds. On June 19, 2006, the dietitian documented the resident appeared nutritionally stable per her weight and food intake. The dietitian recommended that the resident be discontinued from the "nutrition at risk" program. On July 28, 2006, the dietitian documented the resident's weight was stable at 142 pounds.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

As none of the complaints were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

MARCIA KEY, R.N.
Health Facility Surveyor
Long Term Care

MK/dmj

IDAHO DEPARTMENT OF
HEALTH & WELFARE

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September 8, 2006

Rochelle Frank, Administrator
Mountain View Care Center
500 Polk Street East
Kimberly, ID 83341

Provider #: 135084

Dear Ms. Frank:

On **August 15, 2006**, a Complaint Investigation was conducted at Mountain View Care Center. Marcia Key, R.N., Winifred Young, R.N. and Kari Head, R.D. conducted the complaint investigation. A total of 16 survey hours were required to complete this investigation. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00001698

ALLEGATION #1:

The complainant stated an identified resident had no bowel movements for three to four days in July 2006, and again in August 2006.

FINDINGS:

The identified resident's bowel movement frequency was closely monitored by the staff. The resident's bowel record was reviewed for July and August 2006. The resident had bowel movements at least every fourth day. The facility's Daily Bowel Movement List was reviewed for the same time period. According to this documentation the resident received the appropriate interventions on day two, three and four, if no bowel movement, per the facility's protocol. The physician's standing orders identified he was to be notified if the resident had no bowel movement despite interventions after the fourth day.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The complainant stated an identified resident often has no access to water at the bedside. The facility no longer passes the water cart in the afternoon.

An identified nurse stated the resident no longer needed water because she received medications by injections.

FINDINGS:

A tour of the facility was conducted at the start of the investigation. All residents' rooms were observed for availability of fresh water. Most residents had fresh water pitchers in their rooms, including the identified resident. The staff identified which residents required thickened liquids. At random times during the two day investigation the identified resident was observed to have fresh water near her bedside. During observation of her cares a staff member was observed to assist her to drink water. The resident did not have physical signs of dehydration. The resident was also observed during a breakfast and supper meal. The staff was observed to offer the resident the fluids on her tray. Review of her meal monitor records for May through July documented the resident drank a sufficient amount of fluids when she would agree to eat and drink. There were thirteen documented refusals of fluids during meals in May, eight fluid refusals during June, and nine fluid refusals in July, 2006.

Random residents were interviewed. Each resident stated they routinely get fresh water delivered to their rooms twice daily. Random staff were also interviewed and stated the water cart is passed each morning and afternoon routinely.

The identified nurse was unavailable to be interviewed. The resident's record documented the resident received an antibiotic by injection because the resident at times would either refuse to take the antibiotic in pill form, or would take it, then spit it out. The resident received her other routine medications by mouth.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The complainant stated she recently witnessed the identified resident had on an attends which was saturated in urine. The complainant does not believe incontinent care is occurring timely.

FINDINGS:

The identified resident was observed receiving personal cares prior to a meal time. Two staff

removed her attends. It was not saturated with urine. The staff stated the resident's attends were routinely checked upon rising, after meals, at bedtime, and as needed. The resident's perineal area was intact without evidence of irritation from urine or feces. The attends' products are designed to wick away moisture from the skin. At random times during the two day investigation the resident did not smell of urine. Her room also did not have any unpleasant odors.

The resident's care plan identified she was to receive incontinence care in the same manner as the staff indicated.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

As none of the complaints were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

Marcia Key

MARCIA KEY, R.N.
Health Facility Surveyor
Long Term Care

MK/dmj

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135084	A. BUILDING _____ B. WING _____	C 08/15/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW CARE CTR	500 POLK ST E KIMBERLY, ID 83341

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following deficiencies were cited during a complaint investigation at the facility. The surveyors conducting the investigation survey were: Marcia Key, RN Team Coordinator Kari Head, MS, RDLD Survey Definitions: MDS = Minimum Data Set assessment RAI = Resident Assessment Instrument RAP = Resident Assessment Protocol DON = Director of Nursing LN = Licensed Nurse RN = Registered Nurse RD = Registered Dietitian FSM = Food Service Manager CNA = Certified Nurse Aide ADL = Activities of Daily Living MAR = Medication Administration Record	F 000		
F 371 SS=F	483.35(i)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by: Based on a complaint made by the public, observations, record review, and staff interviews, it was determined the facility did not ensure sanitary conditions were maintained in the	F 371		

RECEIVED
SEP - 5 2006
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Donna Robinson
TITLE: Administrator
(X6) DATE: 9/1/06

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135084	A. BUILDING _____ B. WING _____	C 08/15/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW CARE CTR	500 POLK ST E KIMBERLY, ID 83341

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 1 following areas; 1) service of foods at appropriate temperatures, 2) appropriate storage of clean and sanitized equipment and utensils, 3) maintaining dishwashing equipment to prevent deposits of residue, 4) proper maintenance of utensils (mugs), 5) proper monitoring of cold food storage temperatures, and 6) proper employee hygenic practices. This had the potential to effect 100% of the residents who ate at the facility. Findings include: 1. On 8/14/06 at 4:50 pm, an evening tray line service was observed. The menu items served were as follows: Regular: crab salad stuffed tomatoes, three bean salad, sliced peaches, and a honey muffin. Alternate; meat and cheese sandwich, cream of chicken soup, mixed vegetables, and sliced peaches. At 5:09 pm, the cook started to take temperatures for tray service. The first item temped was regular and pureed peaches. The cook placed a digital thermometer into the regular peaches and the readout was in degrees Celsius. The cook asked the surveyor if the °C was for "cold". The surveyor indicated it ment degrees Celsius and to switch to °F. The cook did so and the temperature read 57° F. The cook then asked the surveyor if that was "too cold?" The surveyor directed the cook to ask the FSM or the RD. The cook did not and continued to check temperatures. The pureed peaches were at 61° F. The cook then proceeded to place the peaches on resident trays in the designated tray carts. At the time the peaches were temped, neither the RD or the FSM were in the kitchen. A pan of prepared meat and cheese sandwiches and egg salad sandwiches were placed on the counter where other tray line items	F 371		
		F371	Staff will be/are in serviced on 9/10/06 items to be included are the following: *Taking food temps *Reading of a thermometer *Temping all food items before serving to the residents *Documenting the temp of every food item to be served	9/8/06

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135084	A. BUILDING _____ B. WING _____	C 08/15/2006

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F 371	Continued From page 2	F 371		

where being held for service. When the tray of sandwiches were removed from the fridge, the temperatures were not taken.

Approximately 5-10 minutes later, the RD came into the kitchen and participated in checking the temperature of the other menu items. The pureed crab salad was noted at 60° F and the pureed three bean salad was at 72° F. The RD indicated to the cook that both items needed to be put back in the refrigerator to get the temperature cooler. The cook then placed the pureed crab back in the refrigerator, but left the pureed three bean salad out on the counter. The cook then took the temperature of a large bowel of regular crab salad and was at 50° F. The RD told the cook to put that back in the refrigerator as well. The cook indicated she couldn't understand why the food items were not cold enough because she had made it "like four hours ago." The cook covered the large bowl and put it back in the refrigerator. The cook and the RD were then observed trying to figure out how to put the crab salad on the tray line and keep it cold. They sent someone to get some ice to place in a pan around the crab salad to keep it cold.

Approximately 5 minutes later, a staff member returned with a small amount of ice. At this time, the FSM returned to the kitchen and suggested transferring the crab salad from the big metal bowel into a deep plastic container and placing the plastic container in a pan and surrounding it with ice. The cook then took the regular crab salad out of the refrigerator, and transferred it to the plastic container. The cook did not recheck the temperature of the crab salad to see if in the short time it had been returned to the refrigerator,

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F 371	Continued From page 3 it had come down to the required 41° F. The cook then took the pureed crab salad out of the refrigerator and placed in in the ice next to the regular crab salad on tray line, but did not recheck the temperature. The cook then asked the FSM and RD if she was ready for tray line and they both indicated yes. The cook then started to serve the food. The cook was observed to serve multiple residents food items (regular and pureed crab salad, peaches, and pureed three bean salad) that was found well above the required temperature (41° F) for cold food service. This cook was also observed to serve multiple residents food items whose temperatures were not checked (meat and cheese sandwiches and regular three bean salad). Neither the RD or the FSM prevented residents from being served food that was not at appropriate temperatures. At 5:45 pm, the FSM and RD were asked the procedure for service of out of temperature items. The RD indicated the item should be brought down or up to temperature before service. The RD was then asked why this did not occur during the above observation. The RD did not comment. The FSM was asked the same question and indicated she was unaware that the items served were out of temperature. The FSM was then asked to provide copies of the food temperature logs for the last 30 days. These logs were reviewed and revealed missing temperatures for 27 meals from the regular menu choice and 32 from the alternate choice. The FSM acknowledged the missing temperatures and could not comment on why they were not there. Chapter 3, section 501.14 (B) of the 2005 FDA Food Code indicates, "Potentially hazardous food	F 371	F371 All Cooks will be trained and aware that they need to recheck food temps if on the 1st try the temps are out of compliance. 9/8/06 F371 Food temp. logs will be completed prior to each meal service. The FSD will check daily to be sure theses are being done, and the that appropriate measures are taken if the food is not at an acceptable temperature. 9/8/06	

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F 371	Continued From page 4 shall be cooled within 4 hours to 5°C (41°F) or less, or to 7°C (45°F) as specified under paragraph 3-501.16(A)(2) if prepared from ingredients at ambient temperature, such as reconstituted foods and canned tuna." Chapter 3, section 501.16 (A) of the 2005 FDA Food Code indicates, "Except during preparation, cooking, or cooling, or when time is used as the public health control as specified in sectopm 3-501.19 and except as specified in paragraph (B) of this section, potentially hazardous food shall be maintained: (1) At 60°C (140°F) or above, except that roasts cooked to a temperature and for a time specified in paragraph 3-401.11(B) or reheated as specified in paragraph 3-403.11(E) may be held at a temperature of 54° C (130°F) or above; or (2) At a temperature specified in the following: (a) 5°C (41°F) or less..." 2. a) On 8/14/06 at 2:53 pm, during a tour of the kitchen, a cupboard that contained the boxes of juice for the juice gun was observed to have a shelf that had visible rot and mold from water damage. The shelf was loose and wobbly. When facing the shelf, the far left side contained the water damage and rot. A paper towel was used to wipe the area by the rot and mold and a black and slimy pink substance was found. The FSM acknowledged the area and indicated when the juice gun was placed two weeks ago, she had not noticed the mold. There were multiple plastic beverage pitchers being stored on that shelf. These were removed, cleaned and sanitized and stored in an alternate location until that shelf could be replaced. Chapter 4, section 903.11 of the 2005 FDA Food	F 371		
		F371	A weekly kitchen inspection by the FSD and a monthly inspection by the RD will be done and itemize any areas concern & correction will take place immediately. The Administrator will be notified of problems identified.	9/8/06

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F 371	Continued From page 5 Code indicates, "A) Except as specified in paragraph (D) of this section, cleaned equipment and utensils, laundered linens, and single-service and single-use articles shall be stored: (1) In a clean, dry location; (2) Where they are not exposed to splash, dust, or other contamination..." b) On 8/14/06 at 2:53 pm, during a tour of the kitchen, a cupboard was noted with multiple metal pans stored inverted on a shelf. This shelf was found to be wet from the pans being stacked and put away wet. The FSM was shown the water and agreed the dishes needed to be air dried prior to being stacked and put away. Chapter 4, section 901.11 of the 2005 FDA Food Code indicates, "After cleaning and sanitizing, equipment and utensils: (A) Shall be air-dried or used after adequate draining as specified in paragraph (a) of 21 CFR 178.1010 sanitizing solutions, before contact with food; and (B) May not be cloth dried except that utensils that have been air-dried may be polished with cloths that are maintained clean and dry." c) On 8/15/06 at 10:40 am, two carts of resident beverage pitchers were observed stored in the employee breakroom. The carts were "parked" in front of employee lockers. These lockers were observed with personal items stored within them. One cart appeared to be dirty pitchers returned from the floors, and one cart had a clean towel placed on the top of the pitchers. This towel did not cover all pitchers. At this time the FSM was interviewed and shown the carts. She acknowledged the water pitchers were stored in the breakroom. The FSM indicated when the	F 371	F371 All dishes will be air dried prior to being stored 9/8/06 F371 Clean beverages pitchers and/or any other service utensils, plates, etc. Will be stored in approved areas only. 9/8/06	

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F 371	Continued From page 6 pitchers were cleaned, a towel was placed on them and they were wheeled into the breakroom (across the hall from the dishroom) where they waited until nursing took them to pass water. The FSM indicated they did not know where else to store them because of space constraints within the kitchen. Chapter 4, section 903.12 of the 2005 FDA Food Code indicates, "(A) Except as specified in paragraph (B) of this section, cleaned and sanitized equipment, utensils, laundered linens, and single-service and single-use articles may not be stored: (1) In locker rooms...or (8) Under other sources of contamination." 3. On 8/14/06 at 4:50 pm, 34 8 oz clear plastic glasses and 22 plastic coffee mugs were found stored and ready for use with visible dried white hard water spots on them. The FSM was shown the glasses and indicated they had recently changed the detergent in the dish machine. The FSM acknowledged the spots and indicated they had previous problems with spots on their utensils. On 8/15/06 at approximately 9:30 am, one of the facility's maintenance professionals indicated the water softener to the dish machine had not been "reset" for a while and was probably the reason hard water spots were showing up on the dishes. He then indicated he had just reset it and it was filling with water and should fix the spot concern. Chapter 4, section 501.11 (A) of the 2005 FDA Food Code indicates, "Equipment shall be maintained in a state of repair and condition that meets the requirements specified under Parts 4-1 and 4-2.	F 371	F371 Hard water spots on dishware will be addressed immediately upon identification with the administrator, maintenance dept. and RD. The following steps will be followed: * Maintenance "Reset" the water softener immediately after identification of hard water spots * Dietary staff in serviced on what to do if hard water spots identified *Maintenance to keep a log on when water softener has been reset *FSD will do a spot check on dishware weekly when sanitation check is done	9/8/06

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F 371	Continued From page 7 4. On 8/14/06 at 4:50 pm, two trays of plastic coffee mugs were observed. Multiple (greater than 10) mugs were noted with the glaze gone from the inside food contact surface. Multiple scratches, pits, and gouges were observed in these mugs. The FSM, RD and facility consultant were shown the mugs and acknowledged the mugs were in need of replacement. Chapter 4, section 202.11 (A) of the 2005 FDA Food Code indicates, "Multiuse food-contact surfaces shall be: (1) Smooth; (2) Free of breaks, open seams, cracks, chips, inclusions, pits, and similar imperfections..." 5. On 8/14/06 at 2:53 pm, during a tour of the kitchen, 3 refrigerators and 2 freezers were observed. A "Refrigerator/Freezer Monitoring Log" for August 2006 were noted to have missing temperatures from 8/106 - 8/7/06. The FSM indicated she had to get these forms from a sister facility and thought the temperatures at the beginning of the month were documented on the sheets for July 2006. The FSM was asked to provide copies of July's for review. July 2006 "Refrigerator/Freezer Monitoring Log" were reviewed and no temperatures from 7/1/06 through 7/10/06 were recorded. There were no August temperatures located on these forms either. The FSM acknowledged this and indicated that the cook was gone at the beginning of July was also gone at the beginning of August and the temperatures did not get recorded. 6. On 8/14/06 at 5:09 pm, the cook was observed to removed a sharpie pen from her cleavage area to write down dates and label food that was going	F 371	F371 Any service ware found to have scratches, pits gouges, or missing glaze will discarded and replaced 9/8/06 F371 Food temp logs will be recorded and reviewed daily by FSD 9/8/06	

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F 371	Continued From page 8 into the refrigerator and replace the pen in her cleavage area with the clip part attached to her shirt. This practice was observed to occur three times. The cook did not wash her hands at any time after handling the potentially contaminated pen before returning to food service. Chapter 2, section 301.14 of the 2005 FDA Food Code indicates, "Food Employees shall clean their hands and exposed portions of their arms as specified under section 2-301.12 immediately before engaging in food preparation including working with exposed food, clean equipment and utensils, and unwrapped single-service and single-use articles and: (A) After touching bare human body parts other than clean hands and clean, exposed portions of arms...(I) After engaging in other activities that contaminate the hands..."	F 371	F371 The cook identified on 8/14/06 was immediately pulled form cooking position and retrain started on 8/16/06 (1) Hands will be washed after touching any body part other ther clean hands and arms (2) Per telephone conversation 9/8/06 & Asst Donna Robinson these corrections were verified on 9/14/06 @ 1:33pm	

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C 000	INITIAL COMMENTS The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2. The following deficiencies were cited during a complaint investigation at the facility. The surveyors conducting the investigation survey were: Marcia Key, RN Team Coordinator Kari Head, MS, RDLD Survey Definitions: MDS = Minimum Data Set assessment RAI = Resident Assessment Instrument RAP = Resident Assessment Protocol DON = Director of Nursing LN = Licensed Nurse RN = Registered Nurse RD = Registered Dietitian FSM = Food Service Manager CNA = Certified Nurse Aide ADL = Activities of Daily Living MAR = Medication Administration Record	C 000		
C 299	02.107,05,c c. Menus shall be prepared at least a week in advance. Menus shall be corrected to conform with food actually served. (Items not served shall be deleted and food actually served shall be written in.) The corrected copy of the menu and diet plan shall be dated and kept on file for thirty (30) days.	C 299	C299 1)Menus will be prepared 1 week in advance RD will sign off 2)Food substantiates will be posted on menus 3)Items not served will be deleted from the menu 4)All copies of menus and diet plans will be dated and kept on file for 30 days Alternates per Telephone conversation Donna Robinson Admin on 9/4/06 at 1:32pm	9/8/06

RECEIVED
SEP - 5 2006
FACILITY STANDARDS

Donna Robinson
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
TITLE: Administrator
(X6) DATE: 9/6/06

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C 299	Continued From page 1 This Rule is not met as evidenced by: Based on a complaint from the public, record review, and staff interview, it was determined the facility did not ensure alternative menus were prepared a week in advance. The facility also did not ensure a record was kept of the alternate menus that were served. This had the potential to effect all residents who ate at the facility. Findings include: On 8/14/06 at 3:30 pm, copies of the facility's Spring/Summer cycle menus were reviewed. On these menus, there was no indication what the alternate menu choice for each day was. The copies provided to the surveyor were the copies to be kept on hand that included any substitutions that were made. A daily posting of the menu items, including alternate choices was noted on a dry erase board outside of the kitchen. The regular menu items were crab salad stuffed tomato, three bean salad, honey muffin, and sliced peaches. The alternate menu choice posted was meat and cheese sandwich, cream of chicken soup, mixed vegetables, and sliced peaches. The weekly menu that was posted underneath the dry erase board did not include any alternative menu choices. On 8/14/06 at 4:22 pm, the FSM was interviewed and indicated that the cook was responsible for determining what the alternative meal choice was going to be. When asked when these menu items were determined, the FSM indicated that she encouraged the cooks to have the choices made by the night before for the next lunch and dinner so they could post them. However, they had to have them decided by the morning meal so residents could have the choices at least a meal in advance. The FSM was asked why the alternates were not planned more in advance,	C 299		

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C 299	Continued From page 2 and she indicated it was related to budgetary issues. The FSM indicated she was trying to get the cooks to use up what was in the kitchen. The FSM acknowledged there was no record of what alternative menu items were served to residents. On 8/15/06 at approximately 9:00 am, the facility's consultant was informed of the alternate menus not prepared in advance. At this time, she phoned the dietitian consultant company where the menus were purchased from. The RD on the phone indicated that alternate menu choices were included in all menus provided to facilities. The menus gave facilities examples of how to create alternative menus. The facility could use the examples given or create their own. This same consulting company was contacted via telephone on 8/16/06 at approximately 9:00 am and confirmed that the expectation was for facilities to plan alternate menus at least a week in advance and to keep copies on hand of what menu items were actually served (including alternate menu items) for 30 days.	C 299		
C 325	02.107,08 FOOD SANITATION 08. Food Sanitation. The acquisition, preparation, storage, and serving of all food and drink in a facility shall comply with Idaho Department of Health and Welfare Rules, Title 02, Chapter 19, "Rules Governing Food Sanitation Standards for Food Establishments (UNICODE)." This Rule is not met as evidenced by: Please refer to F 371 as it relates to the storage, preparation and service of food under sanitary conditions.	C 325	Refer to F 371 per conversation C Admin on 8/14/06 at 1:32pm	